State of Montana
Fetal, Infant and Child Mortality Review Case Report

This case report should be completed on all fetal, infant and child deaths reviewed by your local Fetal, Infant and Child Mortality Review team.

The purpose of this report is to help develop a better understanding at the local and state level of how and why the child died and what can be done to deter future preventable deaths.

The information in this report will be tabulated by the Department of Public Health and Human Services FICMR Program and made available to the counties and state as aggregate data.

This reporting tool is a confidential document, protected by Montana Law 50-19-404, and is not subject to disclosure under the public records law.

Death Certificate Number: _____

Case Number: _____-_____
County Number — Sequence of Review/Year of Death/Fetal (F), Infant (I) or Child (C)

County Performing the Review: #_____
(If Different Than Above)

Instructions for Determining Review County For Out of County Deaths:

1) Fetal Death: The death is reviewed by county of residence of the mother. The FICMR Coordinator in the county where the death occurred will assist in obtaining the necessary information for the reviewing county.
2) Child Death: The factors in each case will determine which county completes the review. Child deaths should probably be reviewed by the county in which the death occurred. This allows for development of community action/preventability plans.

Instructions for Determining the Case Report Number When Performing Review for Another County:

1) When reviewing a death for another county (through MOU/Agreement), use their county number in the "case number." Put your county number in the space allowed for "county performing the review".
2) When reviewing a child death that occurred in your county (but child resided in another county), and it is decided that your county will determine preventability and recommendations, utilize your county number in the "case number."

KEY:
○ Implies "Select One Only"
□ Implies "Check All That Apply"

Send Completed Case Report To:
Montana FICMR Program
1400 E Broadway Rm A116
Helena, MT 59620

A. FETUS / INFANT / CHILD INFORMATION

1. DATE OF BIRTH
mm / dd / yyyy

2. DATE OF DEATH
mm / dd / yyyy

3. CAUSE OF DEATH FROM DEATH CERTIFICATE:

4. AGE
a. Infant (<1 year) _____ days/months
b. Child (>1 year) _____ years
c. Fetal _____ weeks gestation

5. RACE (CHECK ONE OR MORE)
a. ☐ White
b. ☐ Black
c. ☐ Asian or Pacific Islander
d. ☐ American Indian
e. ☐ Other
f. ☐ Unknown

6. HISPANIC
a. ◯ Yes b. ◯ No c. ◯ Unknown

7. SEX a. ◯ Male b. ◯ Female

8. RESIDENCE
CITY COUNTY

9. COUNTY WHERE DEATH OCCURRED

10. PLACE WHERE THE INJURY OR FATAL INCIDENT OCCURRED
a. ◯ Child's Home
b. ◯ Other Home
c. ◯ Hospital
d. ◯ Rural Road
e. ◯ Highway
f. ◯ Street
g. ◯ Farm
h. ◯ Private Property
i. ◯ Unlicensed Day Care
j. ◯ Licensed Day Care
k. ◯ Detention Facility
l. ◯ Body of Water
m. ◯ Work Place
n. ◯ Foster Home
o. ◯ Other

11. SUPERVISION ADEQUACY
◯ **N/A (FETAL DEATH OR SUPERVISION NOT NEEDED)**
a. Did the team believe the decedent was adequately supervised
1. ◯ Yes 2. ◯ No 3. ◯ Unsure

12. SUPERVISION ◯ **N/A (I.E. FETAL DEATH)**
Primary person(s) in charge of watching the decedent at the time of the incident (Check all that apply)
a. ☐ Natural Father
b. ☐ Natural Mother
c. ☐ Adoptive Father
d. ☐ Adoptive Mother
e. ☐ Stepfather
f. ☐ Stepmother
g. ☐ Foster Father
h. ☐ Foster Mother
i. ☐ Grandparent
j. ☐ Hospital Staff
k. ☐ Institutional Staff
l. ☐ Babysitter
m. ☐ Licensed Child Care Worker
n. ☐ Friend
o. ☐ Acquaintance
p. ☐ Parent's Male Partner
q. ☐ Parent's Female Partner
r. ☐ Other
s. ☐ Sibling Less Than 18 Years of Age
t. ☐ Due to Age, Supervision Not Needed

13. IF SUPERVISION ADEQUACY IS NO OR UNSURE
a. Did the person(s) in charge appear to be drug or alcohol impaired at the time of the incident
1. ◯ Yes 2. ◯ No 3. ◯ Unknown
b. Was the person(s) in charge preoccupied, distracted, absent or asleep at the time of the injury/event
1. ◯ Yes 2. ◯ No 3. ◯ Unknown
c. Were there justifying circumstances that prevented adequate supervision (I.E. impaired by illness)
1. ◯ Yes, Explain: 2. ◯ No

14. DID PERSON(S) IN CHARGE AT TIME OF DECEASED CHILD'S INCIDENT HAVE A HISTORY OF CHILD MALTREATMENT AS A PERPETRATOR?
1. ◯ No 2. ◯ Yes
If Yes... ◯ On the deceased child ◯ On another child

15. HEALTH INSURANCE
a. ◯ Private Insurance
b. ◯ Medicaid
c. ◯ Uninsured
d. ◯ IHS
e. ◯ CHIP
f. ◯ Other
g. ◯ Unknown

16. MEDICATIONS INFANT/CHILD ON AT TIME OF DEATH
a. ◯ None b. ◯ Unknown c. List Below:

B. PRIMARY CARE GIVER / HOUSEHOLD INFORMATION

1. PRIMARY CAREGIVER
a. ◯ Biological Parent
b. ◯ Adoptive Parent
c. ◯ Step Parent
d. ◯ Foster Parent
e. ◯ Mother's Partner
f. ◯ Father's Partner
g. ◯ Grandparent
h. ◯ Sibling
i. ◯ Other Relative
j. ◯ Friend
k. ◯ Institutional Staff
l. ◯ Other, Specify:
m. ◯ Unknown

2. MARITAL STATUS OF PRIMARY CARE GIVER AT TIME OF FETAL INFANT/CHILD DEATH
a. ◯ Married b. ◯ Single c. ◯ Unknown
d. ◯ Divorced e. ◯ Cohabitating

3. AGE OF PRIMARY CARE GIVER ◯ **UNKNOWN**

4. RACE OF PRIMARY CARE GIVER
a. ◯ White
b. ◯ Black
c. ◯ Asian or Pacific Islander
d. ◯ Unknown
e. ◯ American Indian/Alaskan Native

5. HOMELESS OR MULTIPLE RESIDENCES
a. ◯ Yes b. ◯ No c. ◯ Unknown

6. EVIDENCE OF PREVIOUS ABUSE/NEGLECT OF THIS DECEASED CHILD/ SIBLING BY PRIMARY CAREGIVER

a. ◯ Yes b. ◯ No c. ◯ Unknown

If Yes...

1. ◯ Unsubstantiated 2. ◯ Substantiated 3. ◯ Alleged
4. ◯ Pending 5. ◯ Unfounded

7. OTHER CHILDREN IN THE FAMILY UNIT

a. ◯ Yes b. ◯ No c. ◯ Unknown

If Yes...

1. ◯ 1 2. ◯ 2-3 3. ◯ 4+

8. PRIMARY CARE GIVER HAS HISTORY OF ABUSE/ NEGLECT OF CHILD(REN) OTHER THAN DECEASED CHILD OR SIBLING

a. ◯ Yes b. ◯ No c. ◯ Unknown

If Yes...

1. ◯ Unsubstantiated 2. ◯ Substantiated 3. ◯ Alleged
4. ◯ Pending 5. ◯ Unfounded

9. IS PRIMARY CARE GIVER SAME PERSON AS THE SUPERVISOR IN QUESTION 12

a. ◯ Yes b. ◯ No

C. INVESTIGATION

1. CORONER CASE

a. ◯ Yes b. ◯ No c. ◯ Should Have Been

2. AUTOPSY PERFORMED

a. ◯ Yes b. ◯ No c. ◯ Should Have Been
d. ◯ Unknown

If yes, cause of death listed on autopsy:

3. WAS A TOXICOLOGY DONE

a. ◯ Yes b. ◯ No c. ◯ Unknown

If Yes... (Check all that apply)

1. ☐ Infant 2. ☐ Child 3. ☐ Mother
4. ☐ Father 5. ☐ Care Giver 6. ☐ Other

FINDINGS:

4. SCENE INVESTIGATION CONDUCTED ◯ N/A

a. ◯ Yes b. ◯ No c. ◯ Unknown

If Yes... (Check all that apply)

1. ☐ By Coroner 2. ☐ By Law Enforcement
3. ☐ By Fire Investigator 4. ☐ By EMS
5. ☐ By Other

5. OTHER INVESTIGATION BY LAW ENFORCEMENT ◯ N/A

a. ◯ Not Conducted
b. ◯ Conducted, No Arrest
c. ◯ Conducted, Arrested For: _____
d. ◯ Pending

6. INVESTIGATION BY CHILD & FAMILY SERVICES ◯ N/A

a. ◯ Not Conducted
b. ◯ Conducted, Abuse/Neglect Not Substantiated:
Date Completed _____
c. ◯ Conducted, Abuse/Neglect Substantiated:
Date Completed _____
d. ◯ Pending Investigation, No Children Removed
e. ◯ Other Children Being Removed From Home 1. ◯ Yes 2. ◯ No

7. PRIOR CHILD & FAMILY SERVICES INVOLVEMENT

a. ◯ Yes b. ◯ No c. ◯ Unknown

If Yes.... (Check all that apply)

1. ☐ With Child
2. ☐ With Anyone Else in Family
3. ☐ With the Caregiver (other than family members)
4. ☐ Total # of Referrals to CFS

8. ACTION BY PROSECUTOR ◯ N/A

a. ◯ No Action
b. ◯ Pending or In Progress
c. ◯ Suspected Perpetrator, No Charges Filed
d. ◯ Charges Filed For:

9. FACTORS THAT COULD HAVE CONTRIBUTED TO THE DEATH AS DETERMINED BY THE INVESTIGATION ◯ N/A
(Check all that apply)

a. ☐ Domestic Violence b. ☐ Neglect (physical/mental/emotional)
c. ☐ Child Abuse d. ☐ Alcohol
e. ☐ Drugs f. ☐ Lack of Supervision
g. ☐ Environmental h. ☐ Abandonment
i. ☐ Other

D. SERVICES PROVIDED

1. SERVICES PROVIDED TO FAMILY AS A RESULT OF THE DEATH (Check all that apply)

a. ☐ Bereavement Counseling b. ☐ Economic Support c. ☐ Funeral Arrangements d. ☐ Emergency Shelter
e. ☐ Mental Health Services f. ☐ Child Foster Care g. ☐ Other h. ☐ None Known

E. MANNER, AND CIRCUMSTANCES OF DEATH (Including Fetal)

1. OFFICIAL MANNER OF DEATH FROM DEATH CERTIFICATE

a. ◯ Natural b. ◯ Accident c. ◯ Suicide
d. ◯ Homicide e. ◯ Undetermined f. ◯ N/A (Fetal Death)

2. NATURAL DEATH TO CHILD AGE >1 YEAR UNDERLYING CAUSE: ◯ N/A

a. ◯ Respiratory/Asthma b. ◯ Cancer/Neoplasm
c. ◯ Cerebral d. ◯ Congenital Anomalies
e. ◯ Cardiac f. ◯ Infectious Disease
g. ◯ Other:

3. NATURAL OR UNDETERMINED DEATH TO INFANT AGE 0-1 YEAR INCLUDING SIDS ◯ N/A

(Obtain Birth Record for Completion)

A. AGE AT DEATH

1. ◯ Fetal
2. ◯ 0-23 Hours after Birth
3. ◯ 24-47 Hours
4. ◯ 48 Hours-5 Weeks
5. ◯ 6 Weeks-5 Months
6. ◯ 6 Months-1 Year

B. GESTATIONAL AGE

1. ◯ <24 Weeks
2. ◯ 24-31 Weeks
3. ◯ 32-37 Weeks
4. ◯ >37 Weeks

C. BIRTH WEIGHT IN GRAMS

1. ◯ 350-749
2. ◯ 750-1,499
3. ◯ 1,500-2,499
4. ◯ ≥2,500

D. MULTIPLE BIRTH

1. ◯ Yes
2. ◯ No

E. TOTAL NUMBER OF PRENATAL VISITS

1. ◯ None
2. ◯ 1-3
3. ◯ 4-6
4. ◯ 7-9
5. ◯ >9

F. FIRST PRENATAL VISIT OCCURRED DURING

1. ◯ First Trimester
2. ◯ Second Trimester
3. ◯ Third Trimester
4. ◯ Unknown
5. ◯ No Prenatal Care

G. MEDICAL COMPLICATIONS/INFECTIONS DURING PREGNANCY

◯ Yes ◯ No ◯ Unknown

If Yes... (Check all that apply)

1. ☐ Anemia
2. ☐ Cardiac Disease
3. ☐ Acute/Chronic Lung Disease
4. ☐ Diabetes
5. ☐ Genital Herpes
6. ☐ Hydramnios/Oligohydramnios
7. ☐ Hemoglobinopathies
8. ☐ Hypertension/Pregnancy Associated
9. ☐ Eclampsia
10. ☐ Incompetent Cervix
11. ☐ Renal Disease
12. ☐ Rh Sensitization
13. ☐ Uterine Bleeding
14. ☐ Group B Strep
15. ☐ HIV/AIDS
16. ☐ STD
17. ☐ Hepatitis B Positive
18. ☐ Preterm Labor
19. ☐ Placental Abnormality
20. ☐ Obesity
21. ☐ Other _____

H. TOBACCO USE DURING PREGNANCY

◯ Yes ◯ No ◯ Unknown

If Yes, Average Number of Cigarettes per Day (20 cigarettes per pack)

1. ◯ Less than ½ pack/day
2. ◯ ½-1 pack/day
3. ◯ 1-2 packs/day
4. ◯ >2 packs/day
5. ◯ Unknown

I. ALCOHOL USE DURING PREGNANCY

◯ Yes ◯ No ◯ Unknown

If Yes, Average Number of Drinks per Week

1. ◯ Less than 1/Week
2. ◯ 1-3 Week
3. ◯ 4-6 Week
4. ◯ 7-13 Week
5. ◯ 14 or More per Week
6. ◯ Unknown

J. METHAMPHETAMINE USE DURING PREGNANCY

1. ◯ Yes
2. ◯ No
3. ◯ Suspected
4. ◯ Unknown

K. OTHER DRUG USE DURING PREGNANCY

1. ◯ Yes
2. ◯ No
3. ◯ Unknown

If Yes, Specify Substance(s) _____

1. ◯ Less than 1/Week
2. ◯ 1-3 Week
3. ◯ 4-6 Week
4. ◯ 7-13 Week
5. ◯ 14 or More per Week
6. ◯ Unknown

L. MEDICATIONS MOTHER WAS TAKING AT TIME OF F/I/C DEATH

Specify: _____

1. ◯ None
2. ◯ Unknown

M. WEIGHT GAIN DURING PREGNANCY

1. _____
2. ◯ Unknown

N. MIAMI/HOME VISITING SERVICES DURING PREGNANCY

1. ◯ Yes
2. ◯ No
3. ◯ Unknown

O. INFANT BREAST FED

1. At Hospital Discharge a. ◯ Yes b. ◯ No c. ◯ Unknown
2. At Time of Death a. ◯ Yes b. ◯ No c. ◯ Unknown

4. FETAL/INFANT DEATHS (ADDITIONAL INFORMATION)

A. MATERNAL HISTORY AT TIME OF FETAL/INFANT DEATH

1. Current or Previous History of Post Partum Depression
   a. ◯ Yes b. ◯ No c. ◯ Unknown
2. Total Number of Pregnancies _____
3. Total Number of Full Term Pregnancies (>=37 wks) _____
4. Total Number of Pre Term Pregnancies _____
5. Total Number of Spontaneous or Elective Terminations _____
6. Number of Live Births _____
7. Number Now Living _____

B. PRENATAL CARE PROVIDED BY (Check all that apply)

1. ☐ Family Practice/GP, MD, DO
2. ☐ OB/GYN
3. ☐ Nurse Practitioner/PA
4. ☐ Certified Nurse Midwife
5. ☐ Lay Midwife
6. ☐ Perinatologist
7. ☐ Other
8. ☐ Unknown

C. METHOD OF DELIVERY

Check All of the Following Methods of Delivery that Apply

1. ☐ Vaginal
2. ☐ Vaginal Birth After Previous C-Section
3. ☐ Primary C-Section
4. ☐ Repeat C-section
5. ☐ Forceps
6. ☐ Vacuum
7. ☐ Hysterotomy/Hysterectomy
8. ☐ Unknown

D. COMPLICATIONS OF LABOR AND DELIVERY

1. ◯ Yes
2. ◯ No
3. ◯ Unknown

If Yes... (Check all that apply)

a. ☐ Febrile (>100 ° F. or 38° C.)
b. ☐ Meconium, Moderate/Heavy
c. ☐ Premature Rupture of Membrane >12 hrs)
d. ☐ Abruptio Placenta
e. ☐ Placenta Previa

f. ☐ Other Excessive Bleeding
g. ☐ Seizures During Labor
h. ☐ Precipitous Labor
i. ☐ Prolonged Labor (>20 hours)
j. ☐ Dysfunctional Labor
k. ☐ Breech/Malpresentation
l. ☐ Cephalopelvic Disproportion
m. ☐ Cord Prolapse
n. ☐ Anesthetic Complications
o. ☐ Fetal Distress
p. ☐ Other _____

E. FETAL/INFANT BIRTH HISTORY

1. Location of Birth

a. ◯ Hospital
b. ◯ Outpatient Clinic
c. ◯ Unplanned Home delivery
d. ◯ Out of Hospital
e. ◯ Planned Home Delivery

2. Single or Multiple Birth (Select One)

a. ◯ Single
b. ◯ Twin
c. ◯ Triplet
d. ◯ Other

F. NEWBORN/INFANT BIRTH HISTORY

1. Apgar score 1 minute _____ 5 minutes _____ ◯ Unknown

2. Abnormal Conditions of the Newborn (Check all that apply)

a. ☐ Anemia (HCl, <39 Hgb, <13)
b. ☐ Birth Injury
c. ☐ Fetal Alcohol Syndrome
d. ☐ Hyaline Membrane Disease
e. ☐ Meconium Aspiration Syndrome
f. ☐ Assisted Ventilation (<30 min)
g. ☐ Assisted Ventilation (>30 min)
h. ☐ Seizures
i. ☐ Other _____
j. ☐ None

G. CONGENITAL ANOMALIES

If Yes... (Check all that apply) ◯ No

1. ☐ Anencephalus
2. ☐ Spina Bifida/Meningocele
3. ☐ Hydrocephalus
4. ☐ Other Central Nervous System Anomalies
5. ☐ Heart Malformations
6. ☐ Other Circulatory/Respiratory Anomalies
7. ☐ Rectal Atresia/Stenosis
8. ☐ Trachea-Esophageal Fistula/Esophageal Atresia
9. ☐ Omphalocele/Gastroschisis
10. ☐ Other Gastrointestinal Anomalies
11. ☐ Malformed Genitals
12. ☐ Renal Agenesis
13. ☐ Other Urogenital Anomalies
14. ☐ Cleft Lip/Palate
15. ☐ Polydactyl/Syndactyl/Adactylia
16. ☐ Club Foot
17. ☐ Diaphragmatic Hernia
18. ☐ Other Musculo-Skeletal Integumental Anomalies
19. ☐ Down Syndrome
20. ☐ Other Chromosomal Anomalies
21. ☐ Other _____

H. WAS THE NEWBORN TRANSPORTED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

If Yes, Name of County or Out of State Facility Transferred to:

I. NUMBER OF DAYS HOSPITALIZED PRIOR TO ORIGINAL DISCHARGE _____

J. INFANT CARE PROVIDERS (Check all that apply)

1. ☐ Family Practitioner
2. ☐ Pediatrician
3. ☐ General Practitioner
4. ☐ Nurse Practitioner
5. ☐ Neonatologist
6. ☐ Other
7. ☐ Unknown
8. ☐ None

5. SUDDEN INFANT DEATH SYNDROME (SIDS) AND UNDETERMINED CAUSE UNDER ONE YEAR OF AGE (ALSO COMPLETE E3) ◯ N/A

A. POSITION OF INFANT AT DISCOVERY

1. ◯ On Stomach, Face Down
2. ◯ On Stomach, Face to Side
3. ◯ On Back
4. ◯ On Side
5. ◯ Unknown

B. NORMAL SLEEPING POSITION

1. ◯ On Back
2. ◯ On Stomach
3. ◯ On Side
4. ◯ Varies
5. ◯ Unknown

C. LOCATION OF INFANT WHEN FOUND

1. ◯ Crib
2. ◯ Playpen
3. ◯ Other Bed
4. ◯ Couch
5. ◯ Floor
6. ◯ Other
7. ◯ Unknown

D. INFANT SLEEPING ALONE

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

E. INFANT HEALTHY

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

F. SECOND-HAND CIGARETTE EXPOSURE

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

G. TREATMENT FOR APNEA

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

H. INFANT ON FIRM SURFACE

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

I. HEAVY BEDDING/PILLOWS

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

J. OVERHEATING

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

K. SWADDLED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

L. OTHER RISKS

1. ◯ Yes 2. ◯ No

If Yes, describe:

6. CHILD ABUSE AND NEGLECT (ALSO COMPLETE SECTION F) ○ N/A

A. CAUSE

1. ○ Shaken Baby/Shaken Impact Syndrome
2. ○ Beating/Battered Child
3. ○ Inadequate Supervision
   a. ○ Child's Activity at the Time _____
   b. ○ Resulting Injury _____
4. ○ Medical Neglect for Religious Reasons
5. ○ Failure to Thrive
   a. ○ Non-Organic Failure to Thrive
   b. ○ Malnutrition Due to Neglect
6. ○ Munchausen Syndrome by Proxy
7. ○ Abandonment
8. ○ Scalding
9. ○ Other _____

B. SUSPECTED TRIGGER

1. ○ Crying
2. ○ Disobedience
3. ○ Feeding Difficulty
4. ○ Toilet Training
5. ○ Family Violence
6. ○ Other
7. ○ Unknown

C. DID INVESTIGATION FIND EVIDENCE OF PRIOR ABUSE/ NEGLECT OF DECEASED CHILD

1. ○ Yes 2. ○ No 3. ○ Unknown

If Yes, explain:

D. PRIOR RECORD OF ABUSE/NEGLECT OF DECEASED CHILD

1. ○ Yes 2. ○ No 3. ○ Unknown

If Yes, explain:

E. DECEASED CHILD/FAMILY PREVIOUSLY IDENTIFIED AS HIGH RISK FOR ABUSE

1. ○ Yes 2. ○ No

If Yes, explain:

F. PRIOR SERVICES/TREATMENT PROVIDED

1. ○ Yes 2. ○ No

If Yes, Specify services:

G. WAS PERPETRATOR IDENTIFIED

1. ○ Yes 2. ○ No

If Yes, Perpetrator's Explanation for Injuries:

7. MOTOR VEHICLE AND OTHER TRANSPORT ○ N/A

A. POSITION OF CHILD

1. ○ Driver
2. ○ Pedestrian
3. ○ Passenger ○ Front Seat ○ Back Seat
4. ○ Bicyclist
5. ○ Other

B. TOTAL NUMBER OF VEHICLES INVOLVED IN INCIDENT

1. ○ One 2. ○ Two 3. ○ Three or More

C. VEHICLE RESPONSIBLE FOR INCIDENT

1. ○ Child's Vehicle 2. ○ Other Primary Vehicle

D. DECEASED CHILD'S VEHICLE

1. ○ Car
2. ○ Truck/RV
3. ○ Motorcycle
4. ○ Bicycle
5. ○ SUV
6. ○ Farm Vehicle
7. ○ Water Craft
8. ○ All-terrain
9. ○ Snowmobile
10. ○ Other
11. ○ Unknown

E. OTHER PRIMARY VEHICLE INVOLVED IN INCIDENT ○ NONE

1. ○ Car
2. ○ Truck/RV
3. ○ Motorcycle
4. ○ Bicycle
5. ○ SUV
6. ○ Farm Vehicle
7. ○ Water Craft
8. ○ All-terrain
9. ○ Snowmobile
10. ○ Other
11. ○ Unknown

F. PRIMARY CAUSES OF INCIDENT (Check all that apply)

1. ☐ Speeding Over Limit
2. ☐ Unsafe Speed for Conditions
3. ☐ Recklessness
4. ☐ Ran stop Sign or Red Light
5. ☐ Driver Distraction
6. ☐ Driver Inexperience
7. ☐ Mechanical Failure
8. ☐ Poor Tires
9. ☐ Poor Weather
10. ☐ Poor Visibility
11. ☐ Drugs or Alcohol Use
12. ☐ Fatigue/Sleeping
13. ☐ Medical Event
14. ☐ Backover
15. ☐ Poor Sight Line
16. ☐ Car Changing Lanes
17. ☐ Road Hazard
18. ☐ Animal in Road
19. ☐ Cell Phone Use While Driving
20. ☐ Racing, Not Authorized
21. ☐ Other Driver Error, specify: _____
22. ☐ Other, specify: _____
23. ☐ Unknown

G. CONDITIONS OF ROAD (Check all that apply) ○ N/A

1. ☐ Normal
2. ☐ Ice/Snow
3. ☐ Wet
4. ☐ Loose Gravel
5. ☐ Fog
6. ☐ Construction
7. ☐ Unknown

H. TIME OF DAY

1. ○ 6am-6pm
2. ○ 6pm-12mid
3. ○ 12mid-6am
4. ○ Unknown

I. LOCATION OF INCIDENT (Check all that apply)

1. ☐ City Street
2. ☐ Residential Street
3. ☐ Rural Road
4. ☐ Highway
5. ☐ Intersection
6. ☐ Shoulder
7. ☐ Sidewalk
8. ☐ Driveway
9. ☐ Parking Area
10. ☐ Off Road
11. ☐ Railroad Crossing/tracks
12. ☐ Unknown

J. TYPE OF RESTRAINTS APPROPRIATE (Check all that apply)

1. ☐ Seat Belt
2. ☐ Infant Seat
3. ☐ Toddler Seat
4. ☐ Air Bag-If air bag, did it deploy?
   a. ○ Yes b. ○ No c. ○ Unknown
5. ☐ Not Needed
6. ☐ Unknown

K. RESTRAINT USED

1. ○ Present, Not Used
2. ○ None in Vehicle
3. ○ Used Correctly
4. ○ Used Incorrectly
5. ○ Not Needed
6. ○ Unknown

L. HELMET USE

1. ◯ Helmet Worn 2. ◯ Helmet Not Worn
3. ◯ Not Needed 4. ◯ Unknown

M. ALCOHOL OR OTHER DRUG USE

1. ◯ Yes... (Check all that apply) 2. ◯ No
a. ☐ Child Impaired
b. ☐ Driver of Child's Vehicle Impaired
c. ☐ Driver of Other Vehicle Impaired
d. ☐ Unknown

N. IF M IS YES, SUBSTANCE INVOLVED:

O. AGE OF DRIVER IN CHILD'S VEHICLE

1. ◯ <15 2. ◯ 15-16 3. ◯ 17-18
4. ◯ 19-24 5. ◯ 25-34 6. ◯ 35-59
7. ◯ >60 8. ◯ Unknown

P. AGE OF DRIVER IN OTHER PRIMARY VEHICLE INVOLVED IN THE INCIDENT ◯ N/A

1. ◯ <15 2. ◯ 15-16 3. ◯ 17-18
4. ◯ 19-24 5. ◯ 25-34 6. ◯ 35-59
7. ◯ >60 8. ◯ Unknown

Q. DRIVER OF DECEASED CHILD'S VEHICLE ◯ N/A
(Check all that apply)

1. ☐ Responsible for Causing Incident
2. ☐ Alcohol or Drug Impaired
3. ☐ Has No License
4. ☐ Has a Valid License
5. ☐ Has a Full License, Not Graduated
6. ☐ Has a Suspended License
7. ☐ Has a Graduated License
8. ☐ Was Violating the Following Graduated Licensing Rules
(Check all that apply)
a. ☐ Nighttime Driving Curfew
b. ☐ Passenger Restrictions
c. ☐ Driving Without Required Supervision
d. ☐ Other, specify: _____

_____

R. DRIVER OF OTHER PRIMARY VEHICLE INVOLVED IN INCIDENT ◯ N/A
(Check all that apply)

1. ☐ Responsible for Causing Incident
2. ☐ Alcohol or Drug Impaired
3. ☐ Has No License
4. ☐ Has a Valid License
5. ☐ Has a Full License, Not Graduated
6. ☐ Has a Suspended License
7. ☐ Has a Graduated License
8. ☐ Was Violating the Following Graduated Licensing Rules
(Check all that apply)
a. ☐ Nighttime Driving Curfew
b. ☐ Passenger Restrictions
c. ☐ Driving Without Required Supervision
d. ☐ Other, specify: _____

_____

S. NUMBER OF TEENS IN DECEASED CHILD'S VEHICLE, NOT INCLUDING DECEASED CHILD

1. ◯ None 2. ◯ One 3. ◯ Two
4. ◯ Three or more

T. NUMBER OF TEENS IN OTHER PRIMARY VEHICLE INVOLVED IN INCIDENT ◯ N/A

1. ◯ None 2. ◯ One 3. ◯ Two
4. ◯ Three or More

8. FIRE AND BURN ◯ N/A

A. IF FIRE, THE SOURCE

1. ◯ Matches 2. ◯ Cigarette
3. ◯ Lighter 4. ◯ Gas Explosion
5. ◯ Explosives 6. ◯ Space Heater
7. ◯ Faulty Wiring 8. ◯ Cooking Appliance
9. ◯ Other 10. ◯ Unknown

B. MATERIAL IGNITED

1. ◯ Clothing 2. ◯ Mattress 3. ◯ Furniture
4. ◯ Other 5. ◯ Unknown

C. SMOKE ALARM PRESENT

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

D. SMOKE ALARM WITH GOOD BATTERY

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

E. SMOKE ALARM FUNCTIONING PROPERLY

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

F. FIRE STARTED BY

1. ◯ Victim 2. ◯ Other
3. ◯ No One 4. ◯ Unknown

G. ACTIVITY OF THE PERSON STARTING THE FIRE

1. ◯ Playing 2. ◯ Smoking
3. ◯ Cooking 4. ◯ Suspected Arson
5. ◯ Other 6. ◯ Unknown

H. CONSTRUCTION OF FIRE SITE

1. ◯ Wood Frame Home 2. ◯ Brick Frame Home
3. ◯ Trailer 4. ◯ Other
5. ◯ Unknown

I. FOR BUILDING FIRE, WHERE WAS CHILD FOUND

1. ◯ Hiding 2. ◯ In Bed 3. ◯ Stairway
4. ◯ Close to Exit 5. ◯ Other 6. ◯ Unknown

J. IF BURN, THE SOURCE

1. ◯ Hot water 2. ◯ Appliance 3. ◯ Cigarettes
4. ◯ Heater 5. ◯ Chemicals 6. ◯ Other
7. ◯ Unknown

K. IF WATER BURN, WAS THE CHILD INTENTIONALLY IMMERSED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

9. DROWNING AND SUBMERSION ◯ N/A

A. PLACE OF DROWNING

1. ◯ Lake, River, Pond 2. ◯ Bathtub
3. ◯ In-Ground Swimming Pool 4. ◯ Above-Ground Swimming Pool
5. ◯ Well or Cistern 6. ◯ Bucket
7. ◯ Drainage Ditch 8. ◯ Other

B. ACTIVITY AT TIME OF DROWNING

1. ◯ Boating 2. ◯ Playing at Water's Edge
3. ◯ Swimming 4. ◯ Playing
5. ◯ Bathing 6. ◯ Other
7. ◯ Unknown

C. WAS CHILD WEARING A FLOTATION DEVICE

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

D. DID CHILD ENTER A GATE UNATTENDED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown 4. ◯ N/A

E. IF YES, WAS GATE LOCKED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown 4. ◯ N/A

F. IF SWIMMING, COULD CHILD SWIM

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

G. WERE ALCOHOL OR OTHER DRUGS A FACTOR

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

H. IF POOL, WAS IT COMPLETELY FENCED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

10. FALLS ◯ N/A

A. CHILD FELL FROM

1. ◯ Open Window 2. ◯ Furniture 3. ◯ Natural Elevation
4. ◯ Crib 5. ◯ Stairs/Steps 6. ◯ Bridge
7. ◯ Other

B. WAS CHILD IN A BABY WALKER

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

C. WAS CHILD THROWN OR PUSHED DOWN

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

11. POISONING ◯ N/A

A. TYPE OF POISONING

1. ◯ Alcohol (Estimated Amount)
2. ◯ Prescription Medicine (Name)
3. ◯ Over-the-Counter Medicine (Name)
4. ◯ Chemical (Name)
5. ◯ Carbon Monoxide or Other Gas Inhalation
6. ◯ Foodstuff
7. ◯ Other

B. SAFETY CAP ON BOTTLE

1. ◯ Yes 2. ◯ No 3. ◯ Unknown 4. ◯ N/A

C. LOCATION OF POISON

1. ◯ In Cabinet With Locks or Safety Latch
2. ◯ In Cabinet Without Locks or Safety Latch
3. ◯ On Counter, Table or Floor
4. ◯ Outside or in Garage
5. ◯ Unknown

D. WAS THE POISONING THE RESULT OF

1. ◯ Accidental Overdose 2. ◯ Medical Treatment Mishap
3. ◯ Adverse Effect, but Not OD 4. ◯ Deliberate Poisoning
5. ◯ Unknown

E. FOR CO_2 POISONING, WAS A CO_2 DETECTOR PRESENT & FUNCTIONING PROPERLY

1. ◯ No 2. ◯ Yes 3. ◯ Unknown

12. ELECTROCUTION ◯ N/A

A. SOURCE OF ELECTRICITY

1. ◯ Water Contact 2. ◯ Electrical Wire 3. ◯ Electrical Outlet
4. ◯ Appliance 5. ◯ Tool 6. ◯ Lightning
7. ◯ Other

B. WAS SOURCE DEFECTIVE

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

13. FIREARMS AND WEAPONS ◯ N/A

A. PERSON HANDLING THE WEAPON

1. ◯ Child 2. ◯ Family Member 3. ◯ Acquaintance
4. ◯ Friend 5. ◯ Stranger 6. ◯ Unknown

B. AGE OF PERSON HANDLING WEAPON_____YEARS.

C. TYPE OF WEAPON

1. ◯ Handgun 2. ◯ Rifle 3. ◯ Shotgun
4. ◯ Knife 5. ◯ Unknown 6. ◯ Other

D. IF HANDGUN, WAS IT REGISTERED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

E. USE OF WEAPON AT TIME

1. ◯ Intending To Harm Self 2. ◯ Cleaning
3. ◯ Hunting 4. ◯ Loading
5. ◯ Demonstrating 6. ◯ Playing
7. ◯ Intending to Harm Others 8. ◯ Unknown
9. ◯ Other _____

F. DID PERSON HANDLING FIREARM ATTEND SAFETY CLASSES

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

G. WAS FIREARM IN LOCKED CABINET

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

H. DID FIREARM HAVE A TRIGGER LOCK

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

I. WAS FIREARM STORED WITH AMMUNITION

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

J. WAS FIREARM STORED LOADED

1. ◯ Yes 2. ◯ No 3. ◯ Unknown

14. SUFFOCATION AND STRANGULATION ◯ N/A

A. CIRCUMSTANCES OF EVENT

1. ◯ Other Person Lying On or Rolling On Child
2. ◯ Child On or Covered by Object
3. ◯ Other Person Using Hands or Object to Suffocate/Strangle
4. ◯ Child Choking on Object
5. ◯ Child Strangled by Object
6. ◯ Autoerotic Asphyxiation/ Asphyxiation Game

B. OBJECT CAUSING SUFFOCATION OR STRANGULATION

1. ◯ Unknown 2. ◯ Plastic Bag 3. ◯ Rope/String
4. ◯ Food 5. ◯ Toy 6. ◯ Small Object
7. ◯ Balloon 8. ◯ Person
9. ◯ Bedding Type: _____
10. ◯ Other: _____

C. LOCATION OF CHILD AT THE TIME OF INCIDENT

1. ◯ Crib 2. ◯ In Bed Alone 3. ◯ In Bed With Others
4. ◯ Held in Arms 5. ◯ Playing 6. ◯ Other

D. WAS CHILD SLEEPING

1. ◯ Yes 2. ◯ No 3. ◯ N/A

If Yes...

a. Was the Design of Bed Hazardous 1. ◯ Yes 2. ◯ No
b. Was the Child on Soft Surface 1. ◯ Yes 2. ◯ No
c. Was Child in Heavy Bedding 1. ◯ Yes 2. ◯ No
d. Was the Child Sleeping with Others 1. ◯ Yes 2. ◯ No
e. If Yes, Was Obesity a Factor 1. ◯ Yes 2. ◯ No
f. If Yes, Number and Ages of Persons _____

15. ANY OTHER CAUSE OF DEATH NOT ALREADY COVERED (DESCRIBE THE CIRCUMSTANCES)

F. INFLICTED INJURIES OTHER THAN SUICIDE ● N/A

1. WAS THE INJURY INTENTIONAL

A. ○ YES B. ○ NO C. ○ UNKNOWN

2. IF INTENTIONAL, WAS THE INFANT/CHILD

A. ○ INTENDED VICTIM

B. ○ RANDOM VICTIM (E.G. IN THE LINE OF FIRE)

C. WAS THE INJURY RELATED TO BUYING/SELLING DRUGS

1. ○ Yes 2. ○ No 3. ○ Unknown

D. WAS THE INJURY GANG RELATED

1. ○ Yes 2. ○ No 3. ○ Unknown

E. IF INTENTIONAL, STATUS OF PERPETRATOR (Check all that apply)

1. ☐ Arrested
2. ☐ Charges Filed
3. ☐ Has Record for Similar Offense
4. ☐ Under the Influence of Alcohol/Drugs
5. ☐ Was Receiving Preventive Services
6. ☐ Fled Jurisdiction
7. ☐ Deceased

F. PERSON(S) INFLICTING INJURY (Check all that apply)

1. ☐ Self
2. ☐ Mother
3. ☐ Father
4. ☐ Stepmother
5. ☐ Stepfather
6. ☐ Mother's Boyfriend
7. ☐ Father's Girlfriend
8. ☐ Foster Parent
9. ☐ Acquaintance
10. ☐ Friend
11. ☐ Child Care Worker
12. ☐ Sibling
13. ☐ Other Child
14. ☐ Stranger
15. ☐ Other
16. ☐ Unknown

G. SUICIDE ● N/A

1. CIRCUMSTANCES (CHECK ALL THAT APPLY)

A. A NOTE WAS LEFT

1. ○ Yes 2. ○ No 3. ○ Unknown

B. CHILD TALKED ABOUT SUICIDE

1. ○ Yes 2. ○ No 3. ○ Unknown

C. PRIOR SUICIDE THREATS WERE MADE

1. ○ Yes 2. ○ No 3. ○ Unknown

D. PRIOR SUICIDE ATTEMPTS WERE MADE

1. ○ Yes 2. ○ No 3. ○ Unknown

E. SUICIDE WAS COMPLETELY UNEXPECTED

1. ○ Yes 2. ○ No 3. ○ Unknown

F. CHILD RECEIVED PRIOR MENTAL HEALTH SERVICES

1. ○ Yes 2. ○ No 3. ○ Unknown

G. CHILD WAS RECEIVING MENTAL HEALTH SERVICES

1. ○ Yes 2. ○ No 3. ○ Unknown

H. CHILD WAS ON MEDICATIONS FOR MENTAL ILLNESS

1. ○ Yes 2. ○ No 3. ○ Unknown

I. ISSUES PREVENTED CHILD FROM RECEIVING MENTAL HEALTH SERVICES, SPECIFY:

J. CHILD HAD HISTORY OF RUNNING AWAY

1. ○ Yes 2. ○ No 3. ○ Unknown

K. CHILD HAD HISTORY OF SELF MUTILATION

1. ○ Yes 2. ○ No 3. ○ Unknown

L. FAMILY HISTORY OF SUICIDE

1. ○ Yes 2. ○ No 3. ○ Unknown

M. SUICIDE WAS PART OF A MURDER-SUICIDE

1. ○ Yes 2. ○ No 3. ○ Unknown

N. SUICIDE WAS PART OF A SUICIDE PACT

1. ○ Yes 2. ○ No 3. ○ Unknown

O. SUICIDE WAS PART OF A SUICIDE CLUSTER

1. ○ Yes 2. ○ No 3. ○ Unknown

2. WAS THERE A HISTORY OF ACUTE OR CUMULATIVE PERSONAL CRISIS THAT MAY HAVE CONTRIBUTED TO THE CHILD'S DESPONDENCY (Check all that apply)

a. ☐ None Known
b. ☐ Family Discord
c. ☐ Parent's Divorce/Separation
d. ☐ Argument With Parents/Caregivers
e. ☐ Argument With Boyfriend/Girlfriend
f. ☐ Breakup With Boyfriend/Girlfriend
g. ☐ Argument With Other Friends
h. ☐ Rumor Mongering
i. ☐ Suicide by Friend or Relative
j. ☐ Other Death of Friend or Relative
k. ☐ Bullying as a Victim
l. ☐ Bullying as a Perpetrator
m. ☐ School Failure
n. ☐ Move/New School
o. ☐ Other Serious School Problems
p. ☐ Pregnancy
q. ☐ Physical Abuse/Assault
r. ☐ Rape/Sexual Abuse
s. ☐ Problems With the Law
t. ☐ Drugs/Alcohol
u. ☐ Sexual Orientation
v. ☐ Religious/Cultural Issues
w. ☐ Job Problems
x. ☐ Money Problems
y. ☐ Gambling Problems
z. ☐ Involvement in Cult Activities
aa. ☐ Involvement in Computer/Video Games
bb. ☐ Involvement with the Internet
cc. ☐ Other, specify:

H. MEDICAL CONDITIONS ⬭ N/A

1. HOW LONG DID THE CHILD HAVE THE MEDICAL CONDITION

a. ◯ Since birth b. ◯ Hours c. ◯ Days
d. ◯ Weeks e. ◯ Months f. ◯ Years
g. ◯ Unknown

2. WAS DEATH EXPECTED AS A RESULT OF THE MEDICAL CONDITION

a. ◯ No b. ◯ Yes
c. ◯ Yes, but at a later time d. ◯ Unknown

3. WAS CHILD RECEIVING HEALTH CARE FOR THE MEDICAL CONDITION

a. ◯ No b. ◯ Yes
◯ If yes, within 48 hours of death 1. ◯ No 2. ◯ Yes 3. ◯ U/K

4. WAS CHILD/FAMILY COMPLIANT WITH PRESCRIBED CARE PLANS

a. ◯ Yes b. ◯ Unknown
c. ◯ No (Check all that apply)
1. ☐ Appointments 2. ☐ Medications
3. ☐ Medical Equipment Use 4. ☐ Therapies
5. ☐ Other, specify:

5. WERE PRESCRIBED CARE PLANS APPROPRIATE FOR THE MEDICAL CONDITION

a. ◯ Yes b. ◯ Unknown c. ◯ No, specify:

6. WERE THERE COMPLIANCE OR ACCESS ISSUES RELATED TO THE DEATH

a. ◯ No b. ◯ Unknown
c. ◯ Yes (Check all that apply)
1. ☐ Lack of Money for Care
2. ☐ Limitations of Health Insurance Coverage
3. ☐ Lack of Transportation
4. ☐ No Phone
5. ☐ Cultural Differences
6. ☐ Religious Objections to Care
7. ☐ Language Barriers
8. ☐ Referrals Not Made
9. ☐ Specialist Needed, Not Available
10. ☐ Lack of Child Care
11. ☐ Lack of Family/Social Support
12. ☐ Services Not Available
13. ☐ Caregiver Distrust of Health Care System
14. ☐ Caregiver Unskilled in Providing Care
15. ☐ Caregiver Unwilling to Provide Care
16. ☐ Caregiver's Partner Would Not Allow Care
17. ☐ Other, specify:

I. PREVENTION & TEAM FINDINGS

Must complete every question. A preventable death is one in which, WITH RETROSPECTIVE ANALYSIS, it is determined that a reasonable intervention (e.g., medical, educational, social, legal or psychological) might have prevented the death. Reasonable is defined by taking into consideration the condition, circumstances or resources available.

1. WAS THERE ENOUGH INFORMATION ABOUT THIS DEATH TO DETERMINE PREVENTABILITY

a. ◯ Yes b. ◯ No

2. IF THE ANSWER IS YES, TO WHAT DEGREE WAS THIS DEATH BELIEVED TO BE PREVENTABLE

a. ◯ **NOT AT ALL.** Why was this death not preventable?

b. ◯ **DEFINITELY,** explain:

c. ◯ **CANNOT BE DETERMINED,** explain:

3. PRIMARY RISK FACTORS INVOLVED IN PREVENTABLE DEATH (Check as many as apply)

a. ☐ Medical b. ☐ Social c. ☐ Behavioral
d. ☐ Economic e. ☐ Environmental f. ☐ Product Safety

List examples below and match to risk factors identified (i.e., Behavioral-Smoking)

4. RISK FACTORS FOR UNDETERMINED CAUSES OF DEATH

5. WHAT PREVENTION ACTIVITIES HAVE BEEN PROMPTED BY THE REVIEW SINCE THE DEATH (Check all that apply)

a. Advocacy	1. ☐ Proposed	2. ☐ Initiated
b. Legislation, Law or Ordinance	1. ☐ Proposed	2. ☐ Initiated
c. Community Safety Project	1. ☐ Proposed	2. ☐ Initiated
d. Product Safety Action	1. ☐ Proposed	2. ☐ Initiated
e. Educational Activities in Schools	1. ☐ Proposed	2. ☐ Initiated
f. Educational Activities in Media	1. ☐ Proposed	2. ☐ Initiated
g. Public Forums	1. ☐ Proposed	2. ☐ Initiated
h. New Services	1. ☐ Proposed	2. ☐ Initiated
i. Changes in Agency Practice	1. ☐ Proposed	2. ☐ Initiated
j. Other Programs or Activities	1. ☐ Proposed	2. ☐ Initiated
k. None	1. ☐ Proposed	2. ☐ Initiated
l. Other	1. ☐ Proposed	2. ☐ Initiated

6. TARGET POPULATIONS FOR PREVENTION ACTIVITIES (Check all that apply)

a. ☐ Children b. ☐ General Population
c. ☐ Parents and other Caregivers d. ☐ Professionals
e. ☐ Others f. ☐ Does Not Apply

J. REVIEW TEAM PROCESS

1. DID PANEL MEMBERS CONCUR ON THE CAUSE OF DEATH AS LISTED ON DEATH CERTIFICATE

   a. ⬭ Yes b. ⬭ No

   c. If no, what did the team believe the cause should be:

2. DID PANEL MEMBERS CONCUR ON THE MANNER OF DEATH AS LISTED ON DEATH CERTIFICATE

   a. ⬭ Yes b. ⬭ No

   c. If no, what did the team believe the manner should be:

3. WAS THE DESIGNATION OF CAUSE AND/OR MANNER OF DEATH CHANGED AFTER THE REVIEW

   a. ⬭ Yes b. ⬭ No

4. DID THE REVIEW LEAD TO ADDITIONAL INVESTIGATION

   a. ⬭ Yes b. ⬭ No

   If Yes, Specify By Whom:

5. WERE ADDITIONAL SERVICES PROVIDED AS A RESULT OF THE REVIEW

   a. ⬭ Yes b. ⬭ No

   If Yes, Specify:

6. WERE CHANGES TO LOCAL POLICIES OR PRACTICES RECOMMENDED AS A RESULT OF THIS REVIEW

   1. ⬭ Yes 2. ⬭ No 3. ⬭ Unknown

   If yes... (Check all that apply)

   a. ☐ Public Health b. ☐ Child Family Services
   c. ☐ Other Social Services d. ☐ Medical Examiner
   e. ☐ Law Enforcement f. ☐ Local Government
   g. ☐ State Government h. ☐ Fire
   i. ☐ Education j. ☐ EMS
   k. ☐ Court/Prosecutor l. ☐ Hospital
   m. ☐ Other (Describe)

7. WHICH RECORD(S) WAS THE TEAM <u>UNABLE</u> TO ACCESS (Check all that apply)

   ☐ None

   a. ☐ Hospital b. ☐ Other Medical c. ☐ EMS
   d. ☐ Coroner e. ☐ Birth Record f. ☐ CFS
   g. ☐ Law Enforcement h. ☐ Court i. ☐ School
   j. ☐ Mental Health k. ☐ Health Dept l. ☐ Autopsy
   m. ☐ Other (List)

8. SHOULD THIS CASE BE REFERRED TO THE STATE TEAM FOR A SECOND REVIEW

   a. ⬭ Yes b. ⬭ No

K. NARRATIVE

Provide any additional information that you feel may help to more completely understand issues related to the circumstances of this death, the delivery of services, prevention, or the review process.

L. TEAM PARTICIPATION

Must complete

1. CHECK ALL WHO WERE PRESENT FOR THE REVIEW

a. ☐ County Attorney or Designee
b. ☐ Mental Health
c. ☐ Law Enforcement
d. ☐ Local Trauma Coordinator
e. ☐ Medical Examiner
f. ☐ Tribal Health Representative
g. ☐ Coroner
h. ☐ Bureau of Indian Affairs/Indian Health Service
i. ☐ School District
j. ☐ Emergency Medical Services (EMS)
k. ☐ Pediatrician
l. ☐ Hospital Representative
m. ☐ Family Practice Physician
n. ☐ Hospital Medical Records
o. ☐ Obstetrician/CNM
p. ☐ Fire Department
q. ☐ Nurse Practitioner
r. ☐ Local Registrar
s. ☐ Public Health Nurse
t. ☐ Neonatologist
u. ☐ Child & Family Services
v. ☐ Perinatologist
w. ☐ Social Worker
x. ☐ Other

NAME OF PERSON COMPLETING THE FORM:
DATE REVIEW COMPLETED: (mm/dd/yyyy)
TELEPHONE NUMBER:
QUESTIONS, COMMENTS OR CONCERNS:

MONTANA
Department of Public Health & Human Services